**New Jersey Department of Health and Senior Services**
**Office of Emergency Medical Services**
**PO Box 360, Trenton, NJ 08625-0360**
**609-633-7777 609-633-7839 (Fax)**

# APPLICATION TO UPGRADE PROVIDER LICENSE CLASSIFICATION

**1. Trade Name of Service** (or Corporate Name, if different from trade name)

**2. Current Type of Provider License**
*(Check One Box Only)*

- ☐ Mobility Assistance Provider
- ☐ Mobility Assistance and Basic Life Support Provider
- ☐ Basic Life Support Provider
- ☐ Mobile Intensive Care Provider
- ☐ Basic Life Support and Mobile Intensive Care Provider
- ☐ Mobility Assistance Provider, Basic Life Support and Mobile Intensive Care Provider

**3. Type of Provider License Upgrade Requested**
*(Check One Box Only)*

- ☐ Mobility Assistance and Basic Life Support Provider
- ☐ Mobility Assistance, Basic Life Support and SCTU Provider
- ☐ Basic Life Support and SCTU Provider
- ☐ Basic Life Support, Mobile Intensive Care* and SCTU Provider
- ☐ Mobility Assistance Provider, Basic Life Support, Mobile Intensive Care* and SCTU Provider
- ☐ Mobile Intensive Care* and SCTU Provider

***MICU must have Certificate of Need designation.***

**4. Name of Owner(s)** ***(Attach additional sheet, if needed.)***

| Name | | Social Security Number |
|---|---|---|
| Title | | Date of Birth |
| Office Telephone Number | Mobile Telephone Number | Fax Number |
| Name | | Social Security Number |
| Title | | Date of Birth |

**5. Location Address**

| Street Address | Suite Number |
|---|---|
| City, State, Zip Code | County |

**6. Business Identification** *(Check One Box Only)*

- ☐ Proprietorship (Single Owner - Not Incorporated)
- ☐ Partnership (Not Incorporated
- ☐ Corporation (For Profit)
- ☐ Corporation (Non-Profit)
- ☐ Government Agency
- ☐ Other (Specify):

**7. Mailing Address, If Different From Location Address**

Address / P. O. Box Number

City, State, Zip Code

| **8. Medicaid Provider Number** | **9. FEIN Number** |
|---|---|
| **Signature** | **Date** |

A **NON-REFUNDABLE** certified check or money order in the amount of **$500** must accompany this application.
Make the check or money order payable to: **"Treasurer State of New Jersey."**
(Government agencies do not pay fees. See instructions for more details.)

| **FOR STATE USE ONLY** | | | |
|---|---|---|---|
| **Application Number** | Provider License Valid? | Outstanding Penalties? | Last Provider Survey Date |
| **Date Received** | Amount of Check | Check Number | Transmittal Number |